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Impact of Transformation on Living Condition and Health Inequalities in the Former USSR Countries

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The collapse of state socialism in USSR in 1991 has resulted in rapid and dislocating economic and social changes, which have been accompanied by the dramatic and sudden changes in the life chances and life style, by decline in living conditions and health of the most people of the former Soviet countries. These changes necessitate a sociological explanation, if only because the consequences of the »shock therapy« post-soviet societies underwent, provide a sociological laboratory in which we can examine the effects of dramatic economic and social change on different population groups.

Emile Durkheim has argued that the increase in suicide rates in nineteenth century European societies was an indicator of pathology, and the inability of individuals to use their past cultural base to make sense of a changed society. Similarly, it can be argued that the decline in living conditions and health status in post-soviet societies must be attributable to fundamental social changes.

According to a definition by the World Organization of Public Health the *health* is an individual (personal) state of absolute physical, mental and social well-being, but not only absence of illness or physical defects. In compliance with the World Organization of Public Health finding the public health correlates with the following determinants: life style which explains about 60 percent of the health variables, heredity: 15 percent, social conditions: ten percent, medical problems: eight percent, climate: seven percent.

Thereby this definition underlines the multidimensionality of the health status, which is determined by associated factors among which medical factors are found not only one, and/or not the most important.

As Charles Wright Mills has so convincingly argued (Mills 1959), social ills (as opposed to »personal troubles«) require sociological explanations, then it is essential that we move beyond a descriptive analysis of variables associated with socioeconomic status, social capital, life style and health status, and develop a model of societal change which embeds these phenomena within broader theories of social transformation.

Such a model needs to be sensitive to the intersection of history and biography – the ways in which post-Soviet societies have changed and the consequences of

these changes for the lives of individuals. One way of accomplishing this is to develop a materialist sociological explanation that locates the decline of material and health status within changes in power relationships and economic opportunities, which arise with the introduction of market economies and the integration of the former Soviet Union into global capitalism.

Data-base

This paper is based on statistical data reports and a survey which was undertaken as part of an EU-funded project on living conditions, lifestyle and health (LLH) realized in 2001–2003 with the principal coordination by Christian Haerpfer; in Ukrainian field the survey was coordinated by the research department of the School of sociology at the Kharkiv National university.

The survey investigates how the health of the populations in 8 former USSR countries has been affected by a variety of factors, including socio-economic conditions, cultural and ethnic variables, psycho-social factors and lifestyle.

The study is based on the collection of aggregate level statistics, a sample survey of about 16,500 respondents generally, and detailed case studies involving statistical profiles, 350 in-depth interviews, 14 group interviews.

The Crisis in Post-Soviet Societies

In terms of the cataclysmic nature of events, the depression that the CIS countries experienced through the 1990s was deeper and wider than the Great Depression of the 1920s and 1930s in North America and Western Europe. This is partially due to the fact that the former Soviet Union underwent three major changes in the 1990s which occurred almost simultaneously.
Specifically:

- the boundary of the state and the power structure of the political regime collapsed and new boundaries and institutions had to be introduced;
- the increasingly dysfunctional non-market economy had to be replaced with a new focus of economic organization which entailed elements of a market economy, and the partial integration of post-Soviet economies into globalized capitalism;

– a set of social structures based on privilege had become untenable and was replaced by a system which emulated capitalisteconomic relations, wealth, economic power and exploitation against the backdrop of a haphazardly conducted transfer of public to private wealth.

Throughout the former Soviet Union the transition from planned market economies has been accompanied by a decline in GDP, a decline in state spending on health, education and social security in both absolute and real terms, significant internal migration and an increase in inequalities, poverty, unemployment, underemployment, internal conflict and violent crime. Macroeconomic and social shock inevitably resulted from institutional changes in economics[1].

Nevertheless there were and are notable differences between countries and between regions within countries. By 2002, for example, real GDP was between 95 percent of its 1989 level in Belarus but only 39 percent in Moldova; having fallen dramatically in all the countries during the 1990s (see Table 1).

Economic decline was followed by a sudden growth of social inequality and split according to income, and, in general, economic opportunities (see Tables 2, 3). The Income inequality rate, measured by Ginny coefficient, in Russia and Ukraine towards the mid 1990s increased almost twice compared with late 1980s and reached 47–48 items/units.

1 The conclusion was drawn by Adam Przeworski in 1990, when he foresaw the »start-stop-start« cycle of economic reforming and social feedback in Central and Eastern Europe (Przeworski 1991).

	Belarus	Moldova	Russia	Ukraine	Georgia	Kazakhstan	Czech Republic	Poland
1980	65.7	72.1	78.1	75.0	79.4	87.0	…	91.9
1989	100	100	100	100	100	100	100	100
1990	97.0	97.6	96.0	96.6	87.6	99.6	98.8	88.4
1991	95.8	80.5	91.2	85.4	69.6	86.7	87.3	82.2
1992	86.6	57.1	78.0	73.7	38.4	84.1	86.9	84.4
1993	80.1	56.4	71.2	63.2	28.6	76.4	86.9	87.6
1994	70.0	38.8	62.2	48.8	25.4	66.8	88.9	92.1
1995	62.7	38.3	59.6	42.8	26.0	61.3	94.1	98.6
1996	64.4	35.3	57.5	38.5	28.7	61.6	98.2	104.5
1997	71.8	35.7	58.0	37.4	31.8	62.7	97.4	111.7
1998	77.8	33.4	55.2	36.7	32.7	61.5	96.4	117.1
1999	80.5	31.9	58.2	36.6	33.7	63.1	96.9	121.8
2000	85.1	32.6	63.0	38.7	34.4	69.1	100	126.7
2001	87.3	34.2	66.5	41.4	35.4	76.1	103.1	128.0
2002	95.2	38.6	71.4	47.7	35.2	85.5	105.1	129.8

(Index, 1989 = 100)

Table 1: Real GDP growth in selected Post-Communist countries

(Sources: Economic Survey of Europe, Economic Commission for Europe, Geneva 2003, No. 2, p. 112)

The significant growth in inequality and poverty in the post-Soviet countries created what Richard Rose (1995) described as »an hourglass society«. This society is one, which has a small elite while the majority of the population is living just above, at or below the poverty level.

Selected countries:	1987–1989	1995–1997
Belarus	0.23	0.26
Moldova	0.27	0.41
Russia	0.26	0.47
Ukraine	0.24	0.47
Georgia	0.29	0.37
Kazakhstan	0.30	0.40
Czech Republic	0.19	0.27
Poland	0.26	0.28

Table 2: Inequality in income (Ginny coefficient).

(Source: Transition Report Update 1999. EBRD, London, p. 41)

It is also characterized by strong social integration *within* strata but virtually no vertical integration *between* strata (*Abbott 2002*). In addition, post-Soviet societies now mirror elements of traditional class societies in which a significant proportion of the population is socially excluded.

Economic transformation has brought with it a dramatic transformation in relations of power, entailing the creation of flexible labour markets and structured social exclusion, with the main beneficiaries being a small class of »new capitalists« and global capitalism as a whole (Gorzelak 1996).

However, market transition – the liberal market reform – has not resulted in economic, political and social transformation but in involuntary degeneration that is economic change without genuine economic transformation or the rise of a vibrant civil society.

In parallel with these developments there has been a decommodification of labour, land and money, with a significant proportion of the population dependent on subsistence agriculture and petty commodity production (Burawoy 1997). Thus, the daily lives of the people living in the former Soviet Union have been transformed, with the certainties of everyday life being eroded as the bureaucratic redis-

tributive order has taken on the guise of the market. In parallel, social integration has been undermined (Kolankiewicz 2000) alongside the erosion of the social wage and a significant increase in social inequalities.

Countries:	1990	1991	1992	1993	1994	1996	1998	2000	2002
Belarus	100	93.5	84.1	78.8	70.0	65.7	81.0	94.3	116.5
Kazakhstan	100	96.8	96.2	84.9	67.7	51.3	50.4	53.2	60.4
Moldova	...	...	...	100	82.6	99.7	109.3	107.8	123.3
Georgia	100	79.2	77.1	45.4	42.4	46.1	...	...	...
Russian Federation	100	93.9	89.0	88.1	85.4	80.9	81.4	84.9	97.2
Ukraine	100	94.7	88.7	72.1	65.1	57.5	56.4	55.4	63.1
Czech Republic	104.9	85.5	88.4	90.2	94.5	103.7	101.8	105.4	114.5
Poland	88.3	94.9	98.2	103.0	107.0	118.4	130.8	140.0	146.4

Table 3: Real total Consumption expenditure in selected countries, 1990–2002 (Indices, 1990=100 for CIS or 1989=100 for Poland and Czech Republic)

(Source: Economic Survey of Europe 2003, No. 2 / Economic Commission for Europe, Geneva)

That this transition was accompanied by a marked decline in the health of the population as measured by mortality is perhaps not surprising. However, the decline has not been uniform even within countries, rather it varies by age and by gender. (There has in fact been a *decline* in infant mortality in all post-Soviet countries.) The most obvious increase in mortality in all the countries studied has occurred among middle-aged men (see Table 4).

	Belarus	Moldova	Russia	Ukraine	Georgia	Kazakhstan
Female	-1,7	-1.1	-2.3	-1.4	+2.4	-1.8
Male	-3.4	-1.6	-5.8	-3.6	+4.9	-4.1

Table 4: Female and Male life expectancy at birth (years), difference, 1989–2000

(Source: Redmond G. Social Monitor 2002: the MONEE Project, CEE/CIS/Baltics, Florence: UNICEF, Innocenti Research Centre, 2002)

Male life expectancy at birth declined in all the six countries in the last 1990s with the possible exception of Georgia. The decline in female life expectancy was much

lower. As a consequence the gap between male and female life expectancy increased dramatically.

The decline in male life expectancy was concentrated in mid-life, mainly between the ages of 25 and 59, with the main causes of increased mortality being diseases of the circulatory system and murder, suicide, accident and other external causes – causes that have a sudden effect and can readily be attributed to the dramatic changes in the economic and social circumstances of the population.

This pattern rules out simple explanations in terms of poor diet and consequent low resistance to infection; if the change were due to poverty in this simple and direct sense we should expect increases in death from infectious diseases and, particularly, increased infant mortality.

What Approaches to Explanation Have Been Used?

Most of the work on living conditions and health inequalities in Central and Eastern Europe to date has focused on differences between Eastern and Western Europe and inequalities within the population. Moreover there has been some bias in favor of research on the Russian Federation and research into individual health behavior. In the context of this literature five main approaches have been used for explaining variations in material status and health outcomes:

– Firstly, life style factors – especially tobacco use, diet, alcohol consumption and lack of exercise – have been used to explain health status differences between Russia and Western countries (e.g. Cockerham 2000; Dmitrieva 2001; Palosuo 2000). In particular, the high consumption of spirits in »binges« by men of working age has been seen as the principal »killer«.
– Secondly, political and economic problems such as widening socioeconomic inequalities (people cannot afford good food and medicaments), rising unemployment or the deterioration of the health services have been linked to variations in health outcomes in transition societies (Breev 1998; Shevaldina 1997; Nazarova 2000; Shkolnikov et al. 2000). Brainerd (1998), in a study of 22 transition economies, found that health status was not related to the speed of the transition, but to the GDP growth rate, crime rates and unemployment rates. Tkatchenko et al. (2000) pointed out that the largest decreases in life expectancy occurred in the urban areas of those regions which experienced the most rapid economic change, had the lowest levels of social cohesion and were the wealthiest.
– Thirdly, educational and social status have been linked to health. Accordingly, mortality increased for men and women in all educational groups, but the inc-

rease was largest in the lower educational groups (Shkolnikov/Andreev 2000). Paluoso (2000) and Rose (2003) have all found a strong socio-economic gradient with self-rated health, with Maximova finding that those who reported that their financial position had improved also report improved health and vice versa.

– Fourthly, in an alternative attempt to contextualize the work-related causes of ill health, Woolfson and Beck have linked evidence of deteriorating health indicators amongst working age populations to changes in the legal and regulatory systems governing Workplaces in Post-Soviet States (Woolfson/Beck 2002). According to Woolfson and Beck, Post-Soviet republics face a fundamental dilemma regarding their policies towards workplace health and safety. *On one hand*, most of these countries seek to attract foreign direct investment (FDI) in competition with other provinces. This desire to attract FDI predestines these nations to participate in a »race to the bottom«, especially where the success of policy makers is closely associated with their ability to attract such investment. *On the other hand*, most of the westernized republics of the former Soviet Union in particular are keen to maintain close political ties with Western Europe and the US. Politically, the maintenance of close ties with Western governments, charities and aid agencies, is often conditional on a *de jure* commitment to labour rights and health and safety legislation. These contradictory demands can result in a situation where formal support by ruling elites for labor rights and workplace health and safety legislation is accompanied by neglect of enforcement activities and the toleration of worsening working conditions in key industries such as, mining, construction, forestry and fisheries.

In other words, one facet of deteriorating health among males, in particular, are new forms of hidden exploitation which adversely affects health outcomes either directly, in the form of increased workplace accidents and illnesses, or indirectly by imposing stress factors on individual workers which encourage unhealthy lifestyle choices.

– Lastly, some researchers have suggested that the increase in relative inequalities between regions – the Robin Hood Index – can be used to explain variations in health outcomes (Shkolnikov et al. 2000). Other commentators have suggested that social capital makes an independent contribution to explaining health variations (e.g. Rose 2003).

In attempting to understand the new, dramatic and unprecedented differences in health between western European States and the CIS it is necessary to develop an appropriate sociological framework. One foundation of such theory has to be the acknowledgement of the fact: that the level of societal change in the CIS has been little short of cataclysmic (Alexander 1997; Shkolnikov/Chervyatsov 2000;

Burawoy et al. 2004). About this there can be little doubt. There has been societal transition or involution, which has led to deterioration in health.

Sociologists have made a substantial contribution to the empirically driven socio-epidemiological research which has investigated variations in health between and within countries in terms of *gender, socio-economic variables, ethnicity, place* and so on. The consistency across time and place in health variations between social groups – and in particular the socio-economic health gradient – generally indicates that social factors are of central importance; and that individual genetic differences and life style choice are insufficient on their own to explain them (e.g. Townsend et al. 1988).

In a society where there has been a collapse in the social safety net, a dramatic decline in living standards and an increase in inequalities, these changes will have both a direct impact on health and well-being and an indirect consequence of increased stress, decline in social capital, loss of self esteem, stigma, powerlessness, loss of hope, lack of a feeling of control and fatalism.

Thus in developing a sociological understanding of the phenomenon of declining health, we therefore need to look at relationships of exploitation which can commonly be captured under the mantle of class relations. We have to recognize that the degradation of the economy in post-Soviet societies has resulted in dramatically increased inequality, a new focus on individualisation and the immiseration of a significant proportion of the population. Scambler (2002) has referred to this as the »greedy bastards hypothesis«. In this paper too, emergent Marxist sociological theory of health inequalities (Scambler 2002) together with these drawing on Durkheim and Weber and Bourdieu provides the basis for developing a sociological explanation.

Currently, emerging theoretical positions begin to demonstrate that it is not enough to apply the middle-range heuristics developed to explain inequalities in stable capitalist societies. Rather, in order to comprehend the experience of post-Soviet societies we have to apply the theoretical insights derived from the study of Europe in the great economic, social and health transitional period of the nineteenth century. To develop a sociological understanding of the dramatic decline in health in the former Soviet countries after 1991, the 1990s must be treated as a transition of no less magnitude, affecting all areas of life.

The decline in living standards for the majority of the population, together with the reduced spending on social welfare, has had a direct impact on health. However, the impact it has had is not just a direct effect of, for example, poverty, but a fragmentation and restructuring of a framework of norms and of a whole style of life.

The transition resulted in social fragmentation, a lack of social cohesion and integration and a perceived lack of control over life events.

This process has been illustrated in Figure 1, which highlights the adverse impact of dramatic increases in inequality, a decline in social cohesion and trust, and significantly reduced welfare spending on population and individual health. Transformation has also involved a change in ideology – from one where the collective was emphasized to one based on individual self-reliance and responsibility, a society where there have been real winners and losers (see Table 5), and where the real winners are the new capitalist class and global capitalism.

	Belarus	Georgia	Russia	Ukraine
Difficult to say	4.6	2.5	2.2	1.7
Improved definitely	3.6	0.7	4.7	1.9
Rather improved	17.4	3.5	18.6	9.4
Without changes	3.3	14.1	26.3	15.9
Rather worsen	29.9	42.0	27.8	30.6
Worsen definitely	14.3	37.1	20.5	40.4

Table 5: Changes in material living condition of families for the last 10 years (in percent)

Therefore, a connection has to be made between these larger societal changes – generative mechanisms – and their social consequences. Analytically this involves making a distinction between system integration or disintegration and social integration or disintegration. A crucial problem, of course, is to move from higher levels of theoretical abstraction to the practical issue of dramatically increasing myocardial infraction and similar indicators of societal health disorders. It is therefore necessary to link changes in health status, via middle-range theories, to the economic transition, or to link biography with history.

Accordingly, theories of transition and transformation centre in the first instance on changes which occur at the level of class relations, power and exploitation. Changes at the level of class relations, in turn, bear direct consequences firstly on levels of *social integration*, and, secondly, on the *nature of structure and agency*. Explorations at this level of analysis, lastly, can give rise to middle-range typologies which model societal health collapse in terms of the psycho-social consequences of transition or, alternatively in terms of a rise of individualistic ideology which attaches little value to either individual or collective well being.

In understanding the impact of transformation on health *it is necessary* to understand individuals' place in the sociological scene of the opportunity structures that were created.

Bourdieu (1984) has suggested that, individuals and groups »embody« their social position and this is an important factor in understanding health inequalities. There is evidence that ability to survive or even succeed and exercise a level of control over their lives in post-soviet societies depends on the »resources« that an individual or household is able to »invest«. Those who had stocks of »capital« derived from their location in Soviet society were able to »spend« these even after the break-up of the Soviet Union – only economic capital is alienable (Burawoy et al. ND; Clarke 1999). Life choices are structured by life chances; the majority of the population of post-Soviet societies face restructured life chances and are *unable* to »choose« healthy life styles.

In analyzing data for Russia, R. Rose has suggested that those whose health declined during the transition were those who felt unable to control their lives and those who had suffered most during the transition. This suggests that explanations for the health impact of the transition on different social groups must be sought in the resources, which these are able to utilize in coping with the transition and the coping strategies that they are able to adopt.

Individuals can be broadly classified in terms of strategy towards transition according to the degree to which they embrace or reject transition and according to whether their response is effective or ineffective. Overlapping with these two dimensions is a third dimension, which clarifies individual responses according to whither individuals choose to operate within or without accepted social or legal conventions. Given this matrix, we would expect to observe poor health or worsening health outcomes among most groups with the potential exception of entrepreneurs and low paid professionals with additional earnings, whereby adverse health outcomes would either be the outcome of exposure to violence or to deprivation, or a mixture of both.

We can suggest that there is evidence for the existence of people and households that can cope or can survive in the post-soviet societies and who remain relatively healthy, while there are others who are unable to do so. Taking control over their lives is a key factor and the ability to do so seems to be integrally related to the resources individuals and households are able to invest to help them cope or even succeed in the »new« conditions. Health, or the lack of it, is a key outcome of this – *a measure of »the health of a society«.* Massive deterioration of health and material living conditions, as evidenced in survey data, meanwhile, provides evidence for the cataclysmic character of transformation, which, due to its complexity, makes predictions about future developments difficult if not impossible.

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